STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

see attached

LIVING WILL

- RSA 137-H, Living Wills, was amended by Chapter 239 of the Laws of 1991. This living will statute allows individuals to determine the course of life sustaining medical treatment through a living will document described in RSA 137-H:3 which is to be respected even though the individual can no longer participate in the decision making process due to a terminal condition or if the individual is permanently unconscious. A living will must be executed by a competent adult instructing his/her physician to provide, withhold or withdraw life sustaining medical procedures.

  An attending physician must follow the dictates of the living will as closely as possible. An attending physician or other health care provider is generally immune from liability for making health care decisions in good faith pursuant to the directives of the living will. If the physician is unable to comply with the terms of the document due to personal beliefs or conscience, the physician must so inform the patient or the patient's family.

  A health care facility or health care provider may not require a patient to draft a living will as a condition of receiving health care. Nor may health care be refused because a person has executed or not executed a living will.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

- RSA 137-J, Durable Power of Attorney for Health Care, was enacted by Chapter 146 of the Laws of 1991. This statute allows individuals to maintain control over their medical care during periods of incapacity by prior designating another individual to make the decisions on his/her behalf. The designated party's authority shall be in effect when the attending physician has certified and placed the notation in the medical records, that the patient is unable to make health care decisions. When the patient regains the ability to make the decisions, it will be noted in the medical record. If the patient does not have an attending physician due to religious or moral beliefs, as specified in the document, then the designated party may certify in writing that the patient is incapable of making decisions. The designated party cannot decide to withdraw or withhold artificial nutrition and hydration unless specified in the document. A designated party cannot be the patient's health care provider, a non-relative who is an employee of the patient's health care provider, a resident care provider or a non-relative who is an employee of the patient's residential care provider. A durable power of attorney may be revoked, either orally or in writing, by executing a new durable power of attorney document or by filing an action for divorce when the spouse is the designated party.

  The designated party may review and/or receive any information to assist in making a decision, and the provider is bound by the decision. If a decision is contrary to the health care provider's moral or ethical principles or other standards, the provider may transfer the patient to another facility.

  A patient cannot be charged a different rate nor denied health care because of the existence or non-existence of a durable power of attorney.

LIVING WILL

Declaration made this _____day of_____ (month, year).

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition or a permanently unconscious condition by 2 physicians who have personally examined me, one of whom shall by my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized or that I will remain in a permanently unconscious condition and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary to provide me with comfort care. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial nutrition and hydration. In carrying out any instruction I have given under this section, I authorize that artificial nutrition and hydration not be started or, if started, be discontinued. (yes) (no) (Circle your choice and initial beneath it. If you do not choose "yes", artificial nutrition and hydration will be provided and will not be removed.)

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physicians as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed _____

State of _____

_____County

We, the [declarant and] following witnesses, being duly sworn each declare to the notary public or justice of the peace or other official signing below as follows:

1. The declarant signed the instrument as a free and voluntary act for the purposes expressed, or expressly directed another to sign for him.

2. Each witness signed at the request of the declarant, in his presence, and in the presence of the other witnesses.

3. To the best of my knowledge, at the time of the signing the declarant was at least 18 years of age, and was of sane mind and under no constraint or undue influence.

[_____ Declarant]

_____ Witness

_____ Witness

The affidavit shall be made before a notary public or justice of the peace or other official authorized to administer oaths in the place of execution, who shall not also serve as a witness, and who shall complete and sign a certificate in content and form substantially as follows:

Sworn to and signed before me by _____, declarant _____ and _____, witnesses on _____

_____
Signature

_____
Official Capacity

INFORMATION CONCERNING THE DURABLE
POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your agent, therefore, can have the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent cannot consent or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy unless the failure to withhold the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this document any treatment you do not desire, except as stated above, or treatment you want to be sure you receive. Your agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. If for moral or religious reasons you do not wish to be treated by a doctor or examined by a doctor for the certification that you lack capacity, you must say so in the document and name a person to be able to certify your lack of capacity. That person may not be your agent or alternate agent or any person ineligible to be your agent. You may attach additional pages if you need more space to complete your statement.

If you want to give your agent authority to withhold or withdraw the artifical providing of nutrition and fluids, your document must say so. Otherwise, your agent will not be able to direct that. Under no conditions will your agent be able to direct the withholding of food and drink for you to eat and drink normally.

Your agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have had if made consistent with state law.

It is important that you discuss this document with your physician or other health care providers before you sign it to make sure that you understand the nature and range of decisions which may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Pursuant to RSA 137-J:15, Durable Power of Attorney: Form. The durable power of attorney shall be in substantially the following form:

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I,_____, hereby appoint_____

of _____as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document or as prohibited by law. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTH CARE DECISIONS.

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: cardiopulmonary resuscitation, mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.) There is also a section which allows you to set forth specific directions for these or other matters. If you wish you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

1. If I become permanently incompetent to make health care decisions, and if I am also suffering from a terminal illness, I authorize my agent to direct the life-sustaining treatment be discontinued. (YES) (NO) (Circle your choice and initial beneath it.)

2. Whether terminally ill or not, if I become permanently unconscious I authorize my agent to direct that life-sustaining treatment be discontinued. (YES) (NO) (Circle your choice and initial beneath it.)

3. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial feeding (artificial nutrition and hydration). In carrying out any instructions I have given above in #1 or #2 or any instructions I may write in #4 below, I authorize my agent to direct that (circle your choice of (a) or (b) and initial beside it):

(a) artificial nutrition and hydration not to be started or, if started, be discontinued,

or

(b) although all other forms of life-sustaining treatment be withdrawn, artificial nutrition and hydration continue to be given to me. (If you fail to complete item 3, your agent will not have the power to direct the withdrawal of artificial nutrition and hydration.)

4. Here you may include any specific desires or limitations you deem appropriate, such as when or what life-sustaining treatment your would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. You may leave this question blank if you desire.

_____

_____

_____

_____

_____

(attach additional pages as necessary)

In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint _____ _____of_____ as alternate agent.

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in the disclosure statement.

The original of this document will be kept at _____. and the following persons and institutions will have signed copies:

_____

_____

_____

In witness whereof, I have hereunto signed my name this_____

day of _____, 19 _____

_____

Signature

I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness: _____ Address: _____

Witness: _____ Address: _____

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 19 _____, by _____

_____
Notary Public/Justice of the Peace

My Commission Expires: